ATTACHMENT C PART 4

Pharmacy Services
FCI McKEAN, PA 16701 814-

RX400090296 M. TARR
SIGGERS,KEVIN L
TAKE 1 TABLET EVERY 4-6 HOURS AS NEEDED FOR PAIN

ACETAMINOPHEN 500 MG TABLET #
CG 0 REFILLS EXPIRES

RX 400089761 Pa Hamandi 12/
Siggers, K. 51627-
Take 2 tablets at 5:30pm pill (time change edit by PA Hamar 20/99)

Trazodone Hcl 50mg Tab
cg 2 refills 0

RX400090612 Dr. Olson 12/2
Siggers, K. 5162
Take 1 tablet every 12 hours finished

Cipro 500mg #20
cg 0 refills 01/0

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400090294 M. TARR 12/16/9
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET 4 TIMES A DAY WITH FOOD FOR 10 DAYS UNTIL FINISHED

ERYTHROMYCIN BASE 250 MG TABLET #40
CG 0 REFILLS EXPIRES 12/26/9

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400090295 M. TARR 12/16/9
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET TWICE A DAY **DRINK PLENTY OF FLUIDS**

GUAIFENESIN LA 600MG #10
CG 0 REFILLS EXPIRES 12/21/9

RX400091204 Pa Gomez 1/6/00
Siggers, K. 51627-060
Insert 1 suppository in the rectum twice daily as directed

HC Rectal Suppos #12
cg 1 refill 3/6/00

RX400091205 Pa Gomez 1/6/00
Siggers, K. 51627-060
Apply to rectal area before and after each bowel movement
EXTERNAL USE ONLY

Dibucaine Oint. #1
cg 1 refill 3/6/00

RX400091206 Pa Gomez 1/6/00
Siggers, K. 51627-060
Take 1 capsule every day

Docusate 100mg #10
cg 1 refill 2/6/00

RX400091490 Pa Tarr 1/13/00
Sigger, K. 51627-060
Take 1 tablet twice daily **may make drowsy**

Allerfrim #10
cg 0 refills 1/20/00

RX400091491 Pa Tarr 1/13/00
Siggers, K. 51627-060
Take 1 tablet every 4-6 hours as needed for pain

Acetaminophen 500mg #20
cg 1 refill 2/14/00

RX400090613 Dr. Olson 12/2
Siggers, K. 5162
Take 1 tablet 3 times daily a needed **may make drowsy**

Allerfrim #15
cg 0 refills 01/08

RX400090614 Dr. Olson 12/27
Siggers, K. 51627
Take 2 tablets every 8 hours needed

Acetaminophen 500mg #25
cg 0 refills 01/08/00

CI McKean
O. Box 5000
Bradford. PA 16701

NAME: Siggers, Kevin L. REG.NO. 51627-060

Rx400091801 Pa Tarr 1/25/00
Siggers,K 51627-060
Take 1 tablet twice a day
Cipro 500mg #20
dao 0 Refills 2/6/00

Rx400091802 PA Tarr 1/25/00
Siggers,K 51627-060
Take 1 tablet twice a day
may cause drowsiness
Allerfrim #10
dao 1 Refill 2/6/00

FCI MCKEAN PHARMACY
100020 GOMEZ-LEON 02/03/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
2 DROPS IN AFFECTED RIGHT EAR THREE TIMES DAILY

NEOMYCIN/POLY B/HC OTIC SUSP ML # 10
(0) Refills 02/03/2000 CLO [redacted]
CAUTION: Federal law prohibits transfer of this drug

FCI MCKEAN PHARMACY
100021 GOMEZ-LEON 02/03/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE ONE TABLET TWICE DAILY

TRIPROLIDINE/PSEUDOEPHEDRINE 2.5 # 10
(0) Refills 02/03/2000 CLO [redacted]
CAUTION: Federal law prohibits transfer of this drug

FCI MCKEAN PHARMACY
100022 GOMEZ-LEON 02/03/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE 2 TABLETS EVERY 8 HOURS AS NEEDED

ACETAMINOPHEN 325 MG TAB # 20
(0) Refills 02/03/2000 CLO [redacted]
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
100379 GOMEZ-LEON 02/14/2
SIGGERS, KEVIN LAMAR 51627
MCK - C02-228U
TAKE TWO TABLETS EVERY 6-8 HOURS AS NEEDED

ACETAMINOPHEN 500 MG CAPL #
(1) Refills 02/14/2000 CLO [redacted]
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
102140 FLATT
SIGGERS, KEVIN LAMAR
MCK - C02-228U
TAKE TWO TABLETS FOUR TIMES DAIL NEEDED

ACETAMINOPHEN 500 MG CAPL
(2) Refills 03/30/2000 CLO RxEx
CAUTION: Federal/State law prohibits transfer of to any person other than patient for whom prescri

FCI MCKEAN PHARMACY
102153 HAMANDI 03/30/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE TWO TABLETS AT 8:30PM PILL LINE
Never received chart until 3/30/00 CAO
Clinic 3/3/00. Rx edit 3/30/00.

TRAZODONE 50 MG TAB
(8) Refills 03/30/2000 CLO RxExp
CAUTION: Federal/State law prohibits transfer of this to any person other than patient for whom prescribed

FCI MCKEAN PHARMACY
102907 GOMEZ-LEON 04/
SIGGERS, KEVIN LAMAR 51
MCK - C02-228U
TAKE ONE TABLET TWICE DAILY **MAY C DROWSINESS**

TRIPROLIDINE/PSEUDOEPHEDRINE 2.5
(0) Refills 04/20/2000 CLO RxExp 0
CAUTION: Federal/State law prohibits transfer of this to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
102908 GOMEZ-LEON 04
SIGGERS, KEVIN LAMAR
MCK - C02-228U
TAKE TWO TABLETS EVERY EIGHT HOUR

ACETAMINOPHEN 325 MG TAB
(0) Refills 04/20/2000 CLO # 20 RxExp 05/09/00
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
102909 GOMEZ-LEON 04/20/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE 1 TEASPOONFUL THREE TIMES DAILY **SHAKE WELL**

BISMUTH SUBSALICYLATE 262MG /.15M # 1
(0) Refills 04/20/2000 CLO RxExp 05/09/00
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
103771 FAIRBANKS 05/12/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE TWO TABLETS EVERY EIGHT HOURS AS NEEDED

ACETAMINOPHEN 500 MG CAPL # 21
(0) Refills 05/12/2000 CLO RxExp 05/31/00
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
104036 FAIRBANKS 05/19/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE ONE TABLET TWICE DAILY **MAY CAUSE DROWSINESS**

TRIPROLIDINE/PSEUDOEPHEDRINE 2.5 # 15
(0) Refills 05/19/2000 DAO RxExp 05/28/00
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
104037 FAIRBANKS 05/19/2000
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE TWO TABLETS EVERY EIGHT HOURS AS NEEDED

ACETAMINOPHEN 500 MG CAPL # 15
(0) Refills 05/19/2000 DAO RxExp 06/07/00
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400078682 W. FLATT 01/13/99
SIGGERS,KEVIN L 51627-060
TAKE 2 TABLETS 4 TIMES A DAY AS NEEDED

ACETAMINOPHEN 500 MG TABLET #24
DAO 0 REFILLS EXPIRES 02/12/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400078683 W. FLATT 01/13/99
SIGGERS,KEVIN L 51627-060
INSERT ONE (1) RECTALLY TWICE A DAY

HYDROCORTISONE 25 MG RECTAL SUPPOS #1
DAO 0 REFILLS EXPIRES 01/25/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400078684 W. FLATT 01/13/99
SIGGERS,KEVIN L 51627-060
TAKE 2 CAPSULES AT BEDTIME AS NEEDED **DRINK PLENTY OF WATER**

DOCUSATE SODIUM 100 MG CAPSULE #20
DAO 0 REFILLS EXPIRES 02/12/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400081010 DR. D. OLSON 03/05/99
SIGGERS,KEVIN L 51627-060
TAKE 1&1/2 TABLETS AT 8:30PM PILL LINE

TRAZODONE HCL 50 MG TABLET #45
CG 2 REFILLS EXPIRES 06/03/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400085103 DR. D. OLSON
SIGGERS,KEVIN L
TAKE 1 CAPSULE EVERY DAY **DRINK PLENT WATER**

DOCUSATE SODIUM 100 MG CAPSULE
CG 0 REFILLS EXPIRE

Pharmacy Services
FCI McKEAN, PA 16701 814-3

RX400085104 DR. D. OLSON 0
SIGGERS,KEVIN L 51
INSERT ONE (1) SUPPOSITORIE RECTALLY 3 TI DAY AS NEEDED

HYDROCORTISONE 25 MG RECTAL SUPPOS #1
CG 1 REFILLS EXPIRES 0

Pharmacy Services
FCI McKEAN, PA 16701 814-3

RX400085283 W. HAMANDI 0
SIGGERS,KEVIN L 51
INSERT ONE (1) SUPPOSITORIE RECTALLY AT B

HYDROCORTISONE 25 MG RECTAL SUPPOS #1
CG 1 REFILLS EXPIRES 0

Pharmacy Services
FCI McKEAN, PA 16701 814

RX400085284 W. HAMANDI
SIGGERS,KEVIN L
DISSOLVE ONE (1) TEASPOONFUL IN A GLAS WATER AT BEDTIME

PSYLLIUM HYDROPHILIC MUCILLOID POWDER
CG 0 REFILLS EXPIRE

Pharmacy Services
FCI McKEAN, PA 16701 81

RX400086557 W. HAMANDI
SIGGERS,KEVIN L
TAKE 1 AND 1/2 TABLETS (75MG) AT 8:30P LINE

TRAZODONE HCL 50 MG TABLET
CG 2 REFILLS EXPIR

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400089397 DR. D. OLSON 11/12/99
SIGGERS,KEVIN L 51627-060
INSERT 1 SUPPOSITORIE RECTALLY TWICE A DAY (PA FAIRBANKS)

DOCUSATE SODIUM 100 MG CAPSULE #20
CG 1 REFILLS EXPIRES 12/09/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400089413 M. TARR 11/26/99
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET 4 TIMES A DAY WITH FOOD FOR 7 DAYS UNTIL FINISHED

ERYTHROMYCIN BASE 250 MG TABLET #28
CG 0 REFILLS EXPIRES 12/09/99

RX400089414 M. TARR 11/26/99
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET TWICE A DAY EARLY COURSE

ALLERFRIM TABLETS 60MG-7.5MG #10
CG 0 REFILLS EXPIRES 12/01/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400075617 D. C. OLSON 10/22/98
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET AT 6:45AM PILL LINE AND TAKE 2 TABLETS AT 8:30PM PILL LINE

TRAZODONE HCL 50 MG TABLET #90
CG 0 REFILLS EXPIRES 11/21/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400075905 S. GEORGY 10/28/98
SIGGERS,KEVIN L 51627-060
REFUSAL FORM SIGNED AS PER PA GEORGY 10/28/98 FOR MORNING DOSE OF TRAZODONE

TRAZODONE HCL 50 MG TABLET #1
CG 0 REFILLS EXPIRES 11/27/98

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400076736 R. SAQUIN 11/19/98
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET 1 OR 2 TIMES DAILY AS NEEDED WITH FOOD

IBUPROFEN 400 MG TABLET #20
CG 1 REFILLS EXPIRES 12/09/98

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400076737 R. SAQUIN 11/19/98
SIGGERS,KEVIN L 51627-060
APPLY TO AFFECTED AREA TWICE A DAY **EXTERNAL USE ONLY**

TRIAMCINOLONE 1% TOPICAL CREAM #1
CG 1 REFILLS EXPIRES 12/09/98

Pharmacy Services
FCI McKEAN, PA 16701 814

RX400077360 R. SAQUIN
SIGGERS,KEVIN L
TAKE 1 TABLET AT 8:30 PILL LINE

TRAZODONE HCL 50 MG TABLET #
CG 2 REFILLS EXPIRES

Pharmacy Services
FCI McKEAN, PA 16701 814-

RX400077495 M. TARR
SIGGERS,KEVIN L 5
TAKE 1 TABLET TWICE A DAY UNTIL FINISHED

From 12/4/98 entry

CIPROFLOXACIN HCL 500 MG TABLET #
CG 0 REFILLS EXPIRES

Pharmacy Services
FCI McKEAN, PA 16701 814

RX400078456 M. TARR
SIGGERS,KEVIN L
TAKE 1 TABLET EVERY DAY OR TWICE A DAY NEEDED WITH FOOD

IBUPROFEN 400 MG TABLET #20
CG 1 REFILLS EXPIRES 03/06/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400078681 W. FLATT 01/13/99
SIGGERS,KEVIN L 51627-060
TAKE 2 TABLETS 3 TIMES A DAY UNTIL FINISHED

ERYTHROMYCIN BASE 250 MG TABLET #42
DAO 0 REFILLS EXPIRES 01/20/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400080220 W. FLATT 02/19/99
SIGGERS,KEVIN L 51627-060
TAKE 2 TABLETS 4 TIMES A DAY AS NEEDED

ACETAMINOPHEN 500 MG TABLET #24
CG 2 REFILLS EXPIRES 05/20/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-890

RX400080775 W. FLATT 03/06/99
SIGGERS,KEVIN L 51627-06
TAKE 1 TABLET TWICE A DAY AS NEEDED **MAY CAUSE DROWSINESS**

#10
CG 0 REFILLS EXPIRES 03/10/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-890

W. FLATT 03/02/99
SIGGERS,KEVIN L 51627-060
TAKE 1 TABLET 3 TIMES A DAY AS NEEDED WITH FOOD

#21
CG 0 REFILLS EXPIRES 04/01/99

FCI McKean
P.O. Box 5000
Bradford, PA 16701

NAME: Siggers, Kevin REG. NO.: 51627-060

Place medication label here.	
Place medication label here.	
Place medication label here.	

PHARMACY SERVICES
FTC OKLAHOMA, OK 73189 405-682-4075

RX4964 DR.HUBER 09/24/98
BIGGERS, KEVIN 3C
51627-060 51627-060
TAKE ONE TABLET IN THE MORNING
AND TAKE TWO TABLETS AT
BEDTIME

GENERIC FOR: DESYREL 50MG TAB
TRAZODONE 50MG TAB # 90
HEK 2 REFILL(S) EXPIRES: 12/23/98

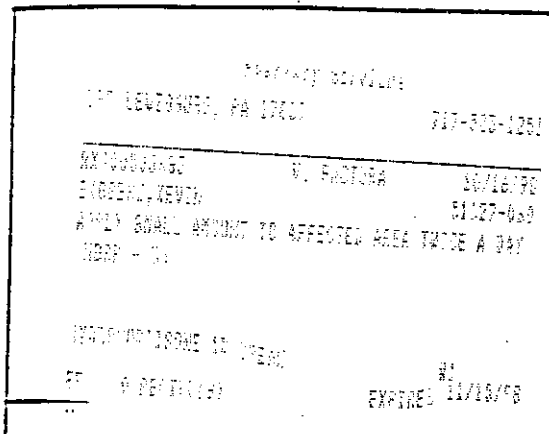
9/25/98

Hal Kessler Rph
Federal Transfer Center, OK

Medication Sheet--Health Services Unit

Federal Transfer Center
Oklahoma City, OK

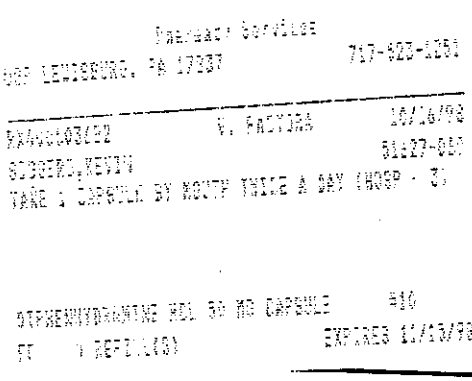
Inmate Name: _____
Inmate Number: _____



Pharmacy Services
[illegible] LEWISBURG, PA 17837 717-523-1251

[illegible] V. PACIGA 10/16/98
[illegible] 01127-0[illegible]
[illegible] GOAL AMOUNT TO AFFECTED AREA TWICE A DAY
[illegible]

[illegible] #1
EXPIRES 11/15/98



Pharmacy Services
USP LEWISBURG, PA 17837 717-523-1251

PA[illegible] V. PACIGA 10/16/98
[illegible] 01127-0[illegible]
TAKE 1 CAPSULE BY MOUTH THREE A DAY (HOSP - [illegible])

[illegible] #10
EXPIRES 11/15/98

Place medication label here.

Place medication label here.

Facility:

Medication Administration Record

Month/Year: December

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Order Date
Exp. Date
RX #

Trazodone 50 mg T @ bedtime P/L

HS ① ①

Order Date

FCI MCKEAN PHARMACY
107892 J. GOMEZ-LEO 09/18/00
SIGGERS, KEVIN LAMAR 51627-060
MCKEAN HOUSING FACILITY - C02-228U
TAKE ONE TABLET AT BEDTIME P/L

TRAZODONE 50 MG TAB #10
(8)Refills 09/18/2000 CLO RxExp 12/16/00

CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

Exp. Date
RX #

FCI MCKEAN PHARMACY
110687 G. FAIRBANKS 12/15/00
SIGGERS, KEVIN LAMAR 51627-060
MCKEAN HOUSING FACILITY - C02-228U
D/C PILL LINE TRAZODONE 50MG AT BEDTIME PER 12/15/00 PSYCH CLINIC PER DR. OLSON.

Order Date
Exp. Date
RX #

TRAZODONE 50 MG TAB #30
(0)Refills 12/15/2000 CLO RxExp 01/13/01

CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

Order Date
Exp. Date
RX #

Order Date
Exp. Date
RX #

Documentation Codes:	**H** - Hold	**R** - Refused	**DC** - Discontinued Order	**S** - Self Administered	**NS** - No Show	**O** - Other

DOB: HT: WT: Allergies: Diagnosis:
Unit:
Pill Line#: **Pt. Name:** Siggers, Kevin **Registration #:** 51627-060 **Physician:**

Medications

FCI MCKEAN PHARMACY

104775 G. FAIRBANKS 06/09/00
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE ONE TABLET AT 8:30PM PILL LINE **DOSE DECREASE**

TRAZODONE 50 MG TAB # 10
(8)Refills 06/09/2000 CLO [redacted]

CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY

107892 J. GOMEZ-LEO 09/18/00
SIGGERS, KEVIN LAMAR 51627-060
MCK - C02-228U
TAKE ONE TABLET AT BEDTIME P/L

TRAZODONE 50 MG TAB # 10
(8)Refills 09/18/2000 CLO RxExp 12/16/00

CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

start: stop:

Rx Label

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

DATE: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

AM / NOON / PM / HS

June 2000

July 2000

August 2000

SEPT 2000

10/00

11/00

INSTITUTION

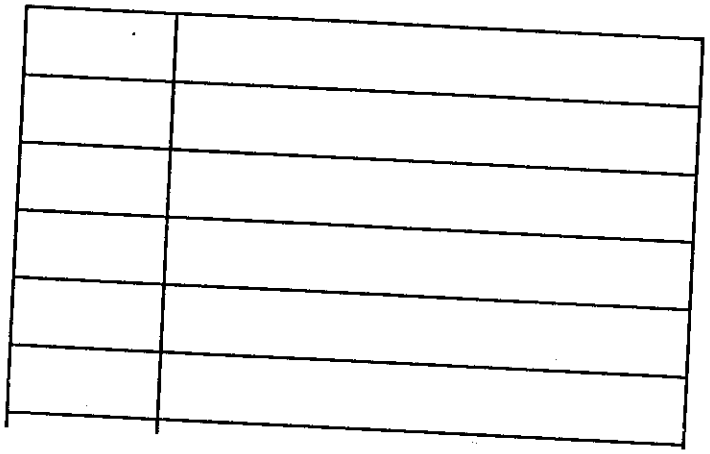
REG. NO.

NAME

Siggers, Kevin Lamar

BP-S216(60) JUNE 1988

USP LVN



Charles Ethridge — Harold Fairbanks — EK

Charles Todd Montgomery — Eric Kessel

Gomez-Leon, José Ismael — PA.

WAYNE FLATT FMG PA

Cheryl Ripperda CAR

Wayne A. Sanders — Cynthia Ann Ayers — CAO

WADE HAMANDI — W. H. Campbell Fitzpatrick — CF

BP-521 (60)
FEBRUARY 1994

U.S. DEPARTMENT OF JUSTICE — Federal Bureau of Prisons — **PILL LINE MEDICATION SHEET**

INSTITUTION: FCI McKean

NAME: Siggers, K. REG. NO. 51627-060

Medications

FCI MCKEAN PHARMACY

102153 HAMANDI 03/30/2000

SIGGERS, KEVIN LAMAR 51627-060

MCK - C02-228U

TAKE TWO TABLETS AT 8:30PM PILL LINE

TRAZODONE 50 MG TAB # 20

(8) Refills 03/30/2000 CLO RxExp 06/27/00

CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

start: stop:

Rx Label

start: stop:

Rx Label

DATE: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

AM / NOON / PM / HS

DEC 1999

JAN 2000

FEB 2000

MAR 2000

APR 2000

MAY 2000

DATE: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

SIGGERS, K.

BP-521 (6/
FEBRUA

U.S. DEPARTMENT OF JUSTICE Federal Bureau of Prisons **PILL LINE MEDICATION SHEET**

INSTITUTION FCI McKean

REG. NO. 51627-060

NAME Siggers, Kevin

Medications

s Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400084986 J. GOMEZLEON 06/07/99
SIGGERS,KEVIN L 51627-060
TAKE 1&1/2 TABLETS (75MG) AT 8:30PM PILL LINE (AT BEDTIME)

TRAZODONE HCL 50 MG TABLET #45
CG 2 REFILLS EXPIRES 09/05/99

Pharmacy Services
FCI McKEAN PA 16701 814-362-8900

RX400086557 W. HAMANDI 09/07/99
SIGGERS,KEVIN L 51627-060
TAKE 1 AND 1/2 TABLETS (75MG) AT 8:30PM PILL LINE

2 REFILLS EXPIRES 12.06/99

2

DATE: 1 2 3 ... 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 ... 30 31

AM
NOON
PM
HS

JULY 1999

AUGUST 1999

SEPTEMBER 1999

OCTOBER 1999

NOVEMBER 1999

DECEMBER 1999

DATE: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

SIGGERS, Kevin

BP-521 (60) FEBRUARY

U.S. DEPARTMENT OF JUSTICE Federal Bureau of Prisons

PILL LINE MEDICATION SHEET

INSTITUTION FCI McKEAN

NAME Siggers, Kevin L REG. NO. 51627-060

Medications

Pharmacy Services

st

FCI McKEAN, PA 16701 814-362-8900

RX400081010 Dr. D. OLSON 03/05/99

SIGGERS,KEVIN L 51627-060

TAKE 1&1/2 TABLETS AT 8:30PM PILL LINE

TRAZODONE HCl 50 MG TABLET #45

CG 2 REFILLS EXPIRES 06/03/99

start: stop:

Rx Label

March 99

April 99

MAY 99

JUNE 99

JULY 99

See new med sheet 7/28/99 CAA

Siggers, Kevin L

DATE: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

AM

NOON

PM

HS

U.S. DEPARTMENT ...CE

Federal Bureau of Prisons

PILL LINE MEDICATION SHEET

BP-521 (... FEBRU...

Medications

BUS MEDS.

RX400... N. ...
SIGGERS, KEVIN ... 51627-060
TAKE 1 TABLET AT 0600 ... TABLETS AT 2000

... #31
... REFILLS EXPIRES ...

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900
RX400075617 Dr. D. OLSON 10/22/98
SIGGERS, KEVIN L 51627-060
~~TAKE 1 TABLET AT 6:45AM PILL LINE AND~~ TAKE 2 TABLETS AT 8:30PM PILL LINE

TRAZODONE HCL 50 MG TABLET #90
CG ... REFILLS EXPIRES .../98

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900
RX400075905 S. GEORGY 10/28/98
SIGGERS, KEVIN L 51627-060
REFUSAL FORM SIGNED AS PER PA GEORGY 10/28/98
FOR MORNING DOSE OF TRAZODONE

TRAZODONE HCL 50 MG TABLET #1
CG 0 REFILLS EXPIRES 11/27/98

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900
RX400081010 Dr. D. OLSON 03/05/99 7/98
SIGGERS, KEVIN L 51627-060 -060
TAKE 1&1/2 TABLETS AT 8:30PM PILL LINE

TRAZODONE HCL 50 MG TABLET #45
CG 2 REFILLS EXPIRES 06/03/99

DATE:	1–31
AM / NOON / PM / HS	Oct. 98
AM / NOON / PM / HS	Nov 98
AM / NOON / PM / HS	Dec 98
AM / NOON / PM / HS	Jan. 99
AM / NOON / PM / HS	Feb. 99
AM / NOON / PM / HS	Mar. 99

SIGGERS KEVIN

NAME Siggers, K. REG. NO. 51627-060 INSTITUTION FCI McKean

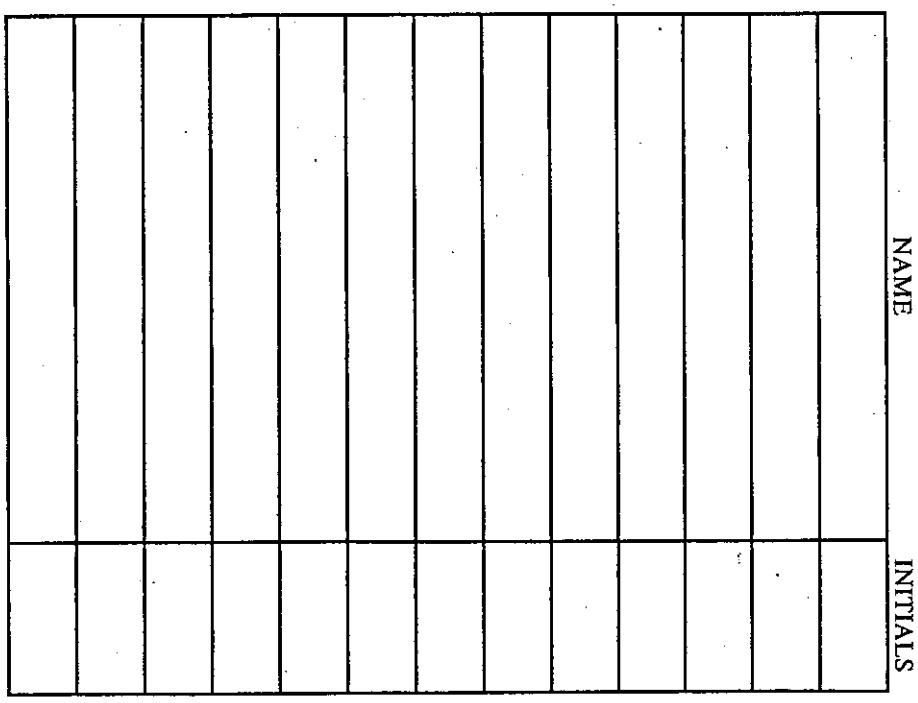
(60) APR 1994

U.S. DEPARTMENT OF JUSTICE — Federal Bureau of Prisons — **PILL LINE MEDICATIO**

NAME _____ REG. NO. _____ INSTITUTION USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG PA 17837

Medications	DATE:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	AM														VH	AF	VH	Q	F	HF											
	NOON																															
	PM													HZ																	
	HS														XH	10	ZR	PH	PH	HF	HF											
	AM																															
	NOON																															
	PM																															
	HS																															
Anthony Bussanich, M.D.	AM																															
start: stop:	NOON																															
	PM																															
Rx Label	HS																															
	AM																															
	NOON																															
	PM																															
	HS																															
start: stop:	AM																															
	NOON																															
	PM																															
Rx Label	HS																															
	AM																															
	NOON																															
	PM																															
	HS																															
	DATE:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

MCK


NAME
INITIALS

SP-521(60) JUNE 1993
USP LVN
Previous editions not usable

NAME   REG. NO.   INSTITUTION

PILL LINE MEDICATION SHEET

U.S. DEPARTMENT OF JUSTICE

Medications	DATE: 1–31
start: stop: Rx Label	AM / NOON / PM / HS
start: stop: Rx Label	AM / NOON / PM / HS
PHARMACY SERVICES (Rx label below)	AM / NOON / PM / HS

PHARMACY SERVICES
FTC OKLAHOMA, OK 73189 405-682-4075
RX 4964 DR.HUBER 09/24/98
SIGGERS, KEVIN 3C
51627-060 51627-060
TAKE ONE TABLET IN THE MORNING
AND TAKE TWO TABLETS AT
BEDTIME
GENERIC FOR: DESYREL 50MG TAB
TRAZODONE 50MG TAB # 90
HEK 2 REFILL(S) EXPIRES: 12/23/98

gone.

REFUSED = 0
NO SHOW = 1
REFUSED = J
NO SHOW = \

MCK

K. Bryan RN ; KMB
Mark M. Carter LPN MMC
Corrections Officer [illegible]

Eloise Knapp LPN EK
Cathy Kendrick LPN CK
Corey [illegible] PA
Kim Haines LPN KG

[illegible] RN HDJ
Kirkwood RN

NAME	INITIALS
[illegible] PA	
GREGORY YOUENS RN	GY
SUSAN FORD ND NP	SF
[illegible] RN	
[illegible] NP	MJ
[illegible] NP	JM
E. STANCOFT DDS	ES
Christina Lacso LPN	CL

NAME	INITIALS
Tammy Lindsey LPN	
Vicki D. Wood LPN	
Becky Bales LPN	
Amy Braund LPN	AB

Edwina Fitz LPN EF
Rhonda Christian LPN R.C
Mark Horn RPh
Hal Keesler RPh
Russell A. Coons Supt
Kent Officer RPh
Nathaniel PD Alexander
Winlock RN WINLOCK
Brown LPN Brown

BP-S620.060 **PATIENT PROBLEM LIST** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

PROBLEM LIST

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
10/28/88	GSW @ Hip 1984 ~		
	Headache Placement + Arthritis		1984
12/4/98	Axis I Depression		
	Axis II - None		
	Axis III - arthritis		
3/26/03	~~MSSA~~ methicillin Resistant Staph Aureus		
9/22/03	AsThma		
2/26/04	PCN (Personal allergic Reaction)		
10/12/04	Gonorrhea/Chlamydia 1995		
	(+) Successful ABX Rx.		
10/12/04	~~Hepatitis~~ Hepatitis B Positive		
	Care level I		

2/26/04
- PCN & Bactrim
- (-) EGGS
- (+) Dust/Mold

ADVERSE / ALLERGIC DRUG REACTIONS
(If none, record "No Known Drug Allergies)

Allergic to Penicillin, BACTRIM
Motrin irritates my stomach.

Patient Identification
(Name, Reg #, DOB)

(This form may be replicated via WP)

Kevin Siggers
51627-060

8/22/70

Medication Summary Sheet

Ord.Date 07/22/04 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 12/18/04 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 170606 — ALBUTEROL INH 90MCG 17GM #1

Ord.Date 07/22/04 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 12/18/04 — INHALE 4 PUFFS TWICE DAILY
Rx # 170607 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #1

Ord.Date 07/22/04 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (1)Refills
Exp.Date 08/30/04 — TAKE ONE TABLET THREE TIMES DAILY WITH FOOD
Rx # 170608 — IBUPROFEN 800 MG TAB #30

Ord.Date 10/12/04 — SIGGERS, KEVIN LAMAR 51627-060 — D. OLSON (0)Refills
Exp.Date 10/26/04 — TAKE ONE TABLET TWICE DAILY UNTIL FINISHED
Rx # 174388 — CIPROFLOXACIN 500 MG TAB #28

Ord.Date 12/21/04 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (3)Refills
Exp.Date 04/19/05 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 177526 — ALBUTEROL INH 90MCG 17GM #1

Ord.Date 12/21/04 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (3)Refills
Exp.Date 04/19/05 — INHALE 4 PUFFS TWICE DAILY
Rx # 177527 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #1

Ord.Date 03/11/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 07/08/05 — INHALE 4 PUFFS TWICE DAILY
Rx # 180733 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #0

Ord.Date 03/11/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 07/08/05 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 180734 — ALBUTEROL INH 90MCG 17GM #0

Ord.Date 03/11/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (0)Refills
Exp.Date 04/09/05 — APPLY TO AFFECTED AREA TWO TIMES A DAY
Rx # 180735 — BACITRACIN OINT #1

Ord.Date 03/25/05 — SIGGERS, KEVIN LAMAR 51627-060 — D. OLSON (0)Refills
Exp.Date 04/23/05 — TAKE ONE TABLET THREE TIMES DAILY WITH FOOD OR MILK AS NEEDED
Rx # 181149 — IBUPROFEN 800 MG TAB #20

Ord.Date 04/21/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (3)Refills
Exp.Date 08/18/05 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 182439 — ALBUTEROL INH 90MCG 17GM #1

Ord.Date 04/21/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (3)Refills
Exp.Date 08/18/05 — INHALE 4 PUFFS TWICE DAILY
Rx # 182440 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #1

Ord.Date 04/21/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (1)Refills
Exp.Date 06/19/05 — TAKE ONE TABLET THREE TIMES DAILY WITH FOOD OR MILK AS NEEDED
Rx # 182441 — IBUPROFEN 800 MG TAB #30

Ord.Date 06/10/05 — SIGGERS, KEVIN LAMAR 51627-060 — E. ASP (3)Refills
Exp.Date 09/07/05 — APPLY TO AFFECTED AREA EACH DAY FOR 15 MINUTES THEN RINSE OFF **EXTERNAL USE ONLY**
Rx # 184548 — SELENIUM SULFIDE LOTION 2.5% ML #1

Ord.Date 06/10/05 — SIGGERS, KEVIN LAMAR 51627-060 — E. ASP (3)Refills
Exp.Date 09/07/05 — APPLY TO AFFECTED AREA DAILY **EXTERNAL USE ONLY**
Rx # 184549 — FLUOCINONIDE 0.05% OINT #1

Ord.Date 08/23/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 01/19/06 — INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED
Rx # 187983 — ALBUTEROL 17 GM MDI #1

Ord.Date 08/23/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (4)Refills
Exp.Date 01/19/06 — INHALE 4 PUFFS TWICE DAILY
Rx # 187984 — TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #1

Ord.Date 08/23/05 — SIGGERS, KEVIN LAMAR 51627-060 — H. BEAM,MD (6)Refills
Exp.Date 11/20/05 — TAKE TWO CAPSULES THREE TIMES DAILY WITH FOOD
Rx # 187985 — INDOMETHACIN 25 MG CAP #30

SIGGERS, KEVIN LAMAR
51627-060
MCKEAN HOUSING FACILITY - C02-
07/22/2004

FCI McKean

Ord.Date 01/19/06 SIGGERS, KEVIN LAMAR 51627-060 H. BEAM,MD (4)Refills

Exp.Date 06/17/06 **INHALE 2 PUFFS FOUR TIMES DAILY AS NEEDED **SHAKE WELL****

Rx # 193993 ALBUTEROL 17 GM MDI #1

Ord.Date 01/19/06 SIGGERS, KEVIN LAMAR 51627-060 H. BEAM,MD (4)Refills

Exp.Date 06/17/06 **INHALE 4 PUFFS TWICE DAILY **SHAKE WELL****

Rx # 193994 TRIAMCINOLONE ACETONIDE 200MCG/INH MDI #1

Ord.Date 01/19/06 SIGGERS, KEVIN LAMAR 51627-060 H. BEAM,MD (6)Refills

Exp.Date 04/18/06 **TAKE TWO CAPSULES THREE TIMES DAILY WITH FOOD**

Rx # 193995 INDOMETHACIN 25 MG CAP #30

BP-S619.060 **IMMUNIZATION RECORD** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
10/28/98	Connaught	097052D	7/20/00	(R) Delt	0.5cc IM	Montgomery	McKean

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
10/28/98	Connaught	248611	10/20/99	(L) FA	0.1cc ID	Montgomery McKean	10/30/98	0x0	Montgomery
10/19/99	Conn.	2506-11	5/00	(L) FA	0.1/10	FCI McKean	10/15/99	0x0	[illegible]
10/3/00	Connaught	CV52AA	10/8/01	(L) FA	5TU ID	C. Rinaldo FCI Mck	10/5/00	0.0	[illegible]
10/24/01	Aventis	C0818AA	1/8/04	(R) FA	0.5cc [illegible]	Chuna Weigard McKean	10/26/01	0x0	[illegible]
10/1/02	Aventis	C0984AA	5/14/04	(L) FA	0.1cc ID	FCI McKean	10/3/02	0x0	[illegible]
10/16/03	Park.	CCU15P	5/04	(L) FA	0.1cc ID	[illegible]	10/18/03	0x0	[illegible]
10/4/04	Park	CCU34P	4/06	RFA	0.1cc ID	RP FCI MCK	10/6/04	0	[illegible]
10/5/05	Park	21851	03/07	(L) FA	0.1cc ID	Douthit McKean	10/7/05	0	[illegible]

Patient Identification
(Name, Reg #)

(This form may be replicated via WP)

Kevin Siggers

51627-060

BP-S619.060 AUG 96 **IMMUNIZATION RECORD** CDFRM

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
3-31-98	Wyeth (R)	4978226	7/99	(R) Del	IM	FMC Roch MGuardalabra	FMC Rochester, MN

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
3/31/98	Connaught	3474-11	5-26-99	(R) Forearm	ID	FMCRoch MQuinlan	4-2-98	0x0	[illegible]

Patient Identification (Name, Reg #)

(This form may be replicated via WP)

SIGGERS, KEVIN L 51627-060
DOB: 08-22-1970

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 10/25/98

1. LAST NAME–FIRST NAME–MIDDLE NAME: Diggers Kevin
2. IDENTIFICATION NUMBER: 51627-060
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): 1371 E. 115th St. Apt. 3 Cleveland, OHIO 44106
5. EMERGENCY CONTACT (Name and address of contact): Gwen Alexander (330)792-1457 2925 Angel Ct. Austintown OHIO 445..
6. DATE OF BIRTH: 8-22-70
7. AGE: 28
8. SEX: ☐ FEMALE ☑ MALE
9. RELATIONSHIP OF CONTACT: Mother
10. PLACE OF BIRTH: Columbus OHIO
11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOP-DOJ
12b. ORGANIZATION UNIT: McKean
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS:

FCI McKean
P.O. Box 5000
Bradford, PA 16701

15. RATING OR SPECIALTY OF EXAMINER:
16. PURPOSE OF EXAMINATION: A+D

17. CLINCIAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	A. HEAD, FACE, NECK AND SCALP	
	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	
	C. DRUMS (Perforation)	
	D. NOSE	
	E. SINUSES	
	F. MOUTH AND THROAT	
	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)	
	H. OPHTHALMOSCOPIC	
	I. PUPILS (Equality and reaction)	
	J. OCULAR MOTILITY (Associated parallel movements nystagmus)	
	K. LUNGS AND CHEST	
	L. HEART (Thrust, size, rhythm, sounds)	
	M. VASCULAR SYSTEM (Varicosities, etc.)	
	N. ABDOMEN AND VISCERA (Include hernia)	
NE	O. PROSTATE (Over 40 or clinically indicated)	
	P. TESTICULAR	
	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
	R. ENDOCRINE SYSTEM	
	S. G-U SYSTEM	
	T. UPPER EXTREMITIES (Strength, range of motion)	
	U. FEET	
	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	W. SPINE, OTHER MUSCULOSKELETAL	
	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X
	Y. SKIN, LYMPHATICS	
	Z. NEUROLOGIC (Equilibrium tests under item 41)	
	AA. PSYCHIATRIC (Specify any personality deviation)	
	BB. BREASTS	
	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 1 2 3 / 32 31 30 — 0 / 0
Non-restorable teeth: 1 2 3 / 32 31 30 — X / X
Missing Teeth: 32 31 30
Replaced by Dentures: X X X / 1 2 3 / 32 31 30 — X X X
Fixed Partial Dentures: [X] / 1 2 3 / 32 31 30 — [X]

RIGHT																LEFT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES:

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC
B. CHEST X-RAY OR PPD (Place, date, film number and result)
C. SYPHILIS SEROLOGY (Specify test used and results)
D. EKG
E. BLOOD TYPE AND RH FACTOR
F. OTHER TESTS

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
60"	239	blk	brn	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	97.8

26. BLOOD PRESSURE (Arm at heart level)						27. PULSE (Arm at heart level)				
		B. RECUMBENT		C. STANDING (5 mins.)		A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
A. SITTING	SYS. 120		SYS.		SYS.	70bpm				
	DIAS 80		DIAS.		DIAS.					

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/ 50	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 70	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA (Specify distance)

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION (Test used and result)	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
35. FIELD OF VISION		36. NIGHT VISION (Test used and score)	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

1984 GSW ® Hip Hardware placed in Hosp 3 mos
multiple surgeries from
1995 fx T12 fall Knee
Hx arthritis - back scar from Hatchet ® Knee

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

HEENT clear
Hrt RRR ⊖ m
⊖ wss ⊖ Organomegaly
Multiscars

Flow sign UE + LE

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR Full Duty

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

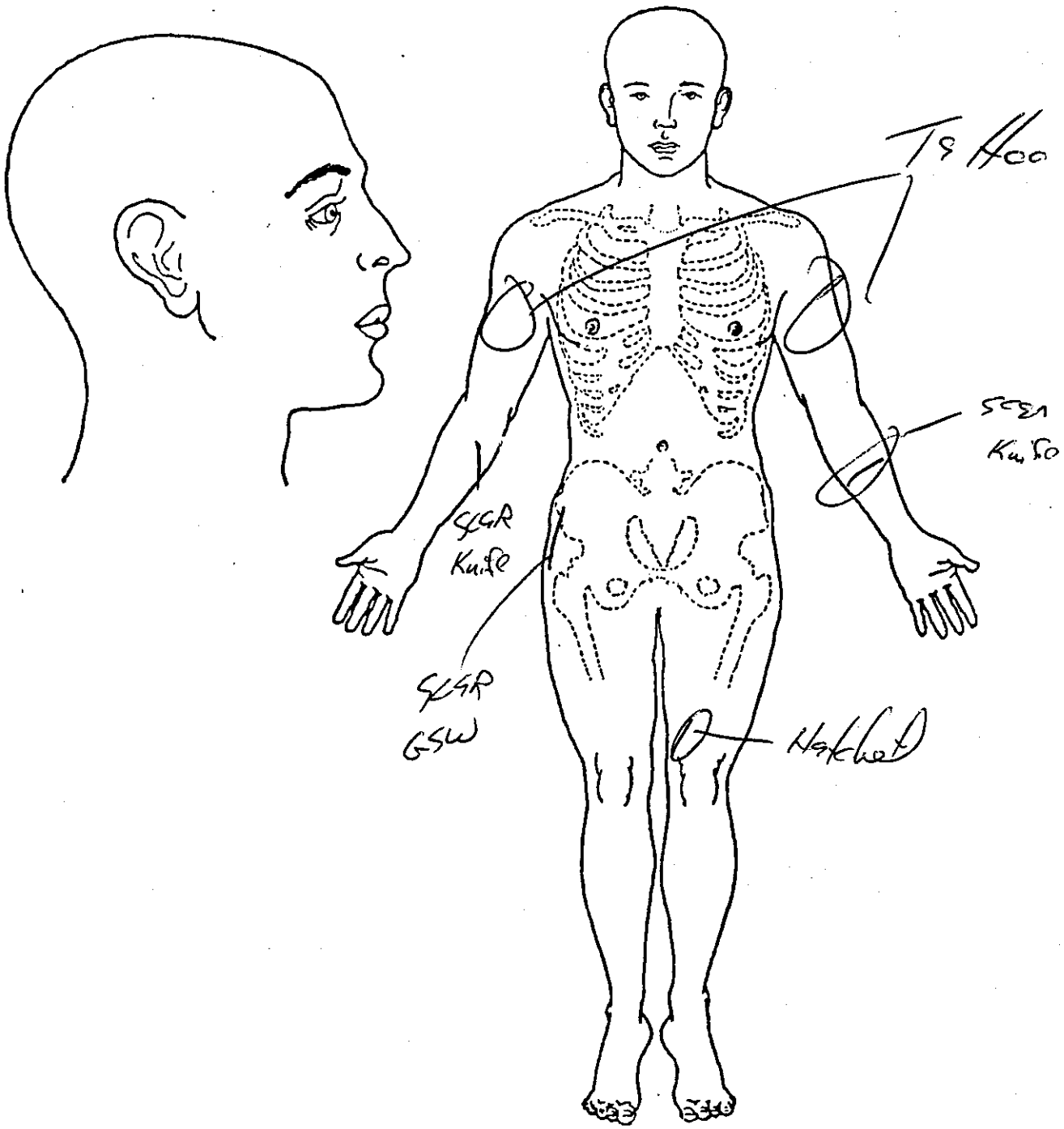
A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
T. Montgomery, MLP	
49. TYPED OR PRINTED NAME OF PHYSICIAN OLSON M.D.	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

*U.S. Government Printing Office: 1996 - 404-763/20080

531-110 NSN 7540-00-634-4274

MEDICAL RECORD | **ANATOMICAL FIGURE**



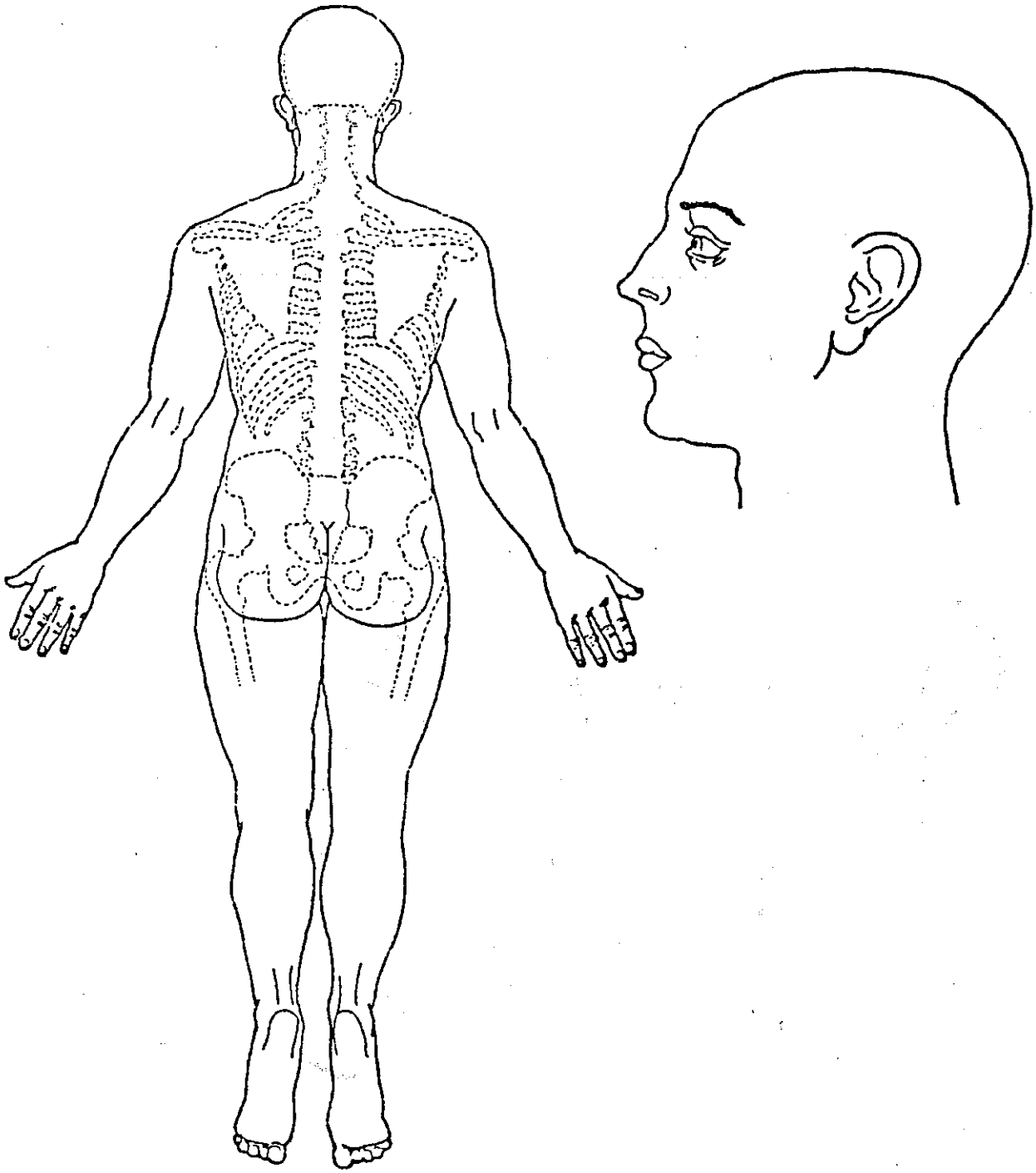
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)*

REGISTER NO.	WARD NO.
51627-060	

ANATOMICAL FIGURE

Kevin Siggers

STANDARD FORM 531 (Rev. 4-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1



*U.S. Government Printing Office: 1992 — 312-071/50064

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
SIGGERS LEONE LAMAR	51627-066

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
I/S	10/13/98	USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG, PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses (1)
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever
	✓		Rheumatic fever
	✓		Swollen or painful joints
	✓		Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
	✓		Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
	✓		Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
✓			Adverse reaction to serum drug or medicine (6)
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
✓			Recent gain or loss of weight
			Arthritis, Rheumatism, or Bursitis (3)
			Bone, joint or other deformity (3)
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "Trick" shoulder or elbow
			Recurrent back pain (2)
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
✓			Frequent trouble sleeping (4)
✓			Depression or excessive worry (4)
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness
	✓		Have you ever had homosexual contact?
	✓		Been exposed to AIDS
	✓		Alcohol Use (Excessive)
	✓		Drug Use/Addiction
	✓		Marijuana (5)
	✓		Cocaine
	✓		Heroin
	✓		L.S.D.
	✓		Amphetamines
	✓		Others: (Specify)
			Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

	Been treated for a female disorder
	Had a change in menstrual pattern
	ARE YOU PREGNANT
	SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

LABOR

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.	✓		19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
✓		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
✓		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
✓		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

14. Be seeing a psychologist since childhood.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE Kim Tsyzin 51627-060

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? none.

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? none

DUTY STATUS: TEMPORARY WORK ✓ RESTRICTED ___

GENERAL POPULATION ___ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

① Glasses not w/ him ⊘ suicidal thoughts

② fx T12 fell down stairs

③ arthritis whole body. metal in chips (pins / plates) while playing soccer.

④ Depression – psychologist all his life. Just placed on meds in Rochester – July 98.

⑤ 1 yr ago

⑥ PCN → hives eggs → hives

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Hope E. Zeiber, RN	10/13/98		

REVERSE

P-S360.060 MEDICAL HISTORY - BP DOFRM MAY 1994

J.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME		2. REGISTER NUMBER
3. PURPOSE OF EXAMINATION Intake Screening	4. DATE OF EXAMINATION	5. EXAMINING FACILITY Federal Transfer Center, Oklahoma City, OK

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever	✓			Adverse reaction to		✓		Epilepsy or fits
	✓		Rheumatic fever				drug or medicine		✓		Car,train,sea or air sickness
	✓		Swollen or painful		✓		Broken bones	✓			Frequent trouble sleeping
		✓	joints		✓		Tumor,growth,cyst,cancer	✓			Depression or excessive worry
	✓		Frequent or severe		✓		Rupture/hernia		✓		Loss if memory or amnesia
✓			headache		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Dizziness or fainting	✓			Frequent or				Periods of unconsciousness
	✓		spells	✓			painful urination				Have you ever had
✓		✓	Eye trouble		✓		Bed wetting since age 12				homosexual contact?
	✓	✓	Ear,nose,throat trouble	✓			Kidney stone or		✓		Been exposed to AIDS
	✓	✓	Hearing loss	✓			blood in urine			✓	Alcohol Use (Excessive)
	✓		Chronic, frequent colds			✓	Sugar, albumin in urine				Drug Use/Addiction
✓			Sever tooth, gum trouble		✓		VD-Syphilis, gonorrhea,	✓			Marijuana
	✓		Sinusitis		✓		etc.				Cocaine
	✓		Hay Fever	✓			Recent gain or loss of				Heroin
	✓		Head injury				weight				L.S.D.
	✓		Skin diseases	✓			Arthritis, Rheumatism,				Amphetamines
			Thyroid trouble		✓		or Bursitis				Others: (Specify)
			Tuberculosis	✓			Bone, joint or				
			Asthma	✓			other deformity			✓	Alcohol or drug
			Shortness of breath		✓		Lameness				Withdrawal Problems

(This form may be replicated via WP)

This form replaces BP-360(60) dated January 1986.

		Pain, pressure in chest			Loss of finger or toe		
		Chronic cough			Painful or "Trick" shoulder or elbow	10. FEMALES ONLY HAVE YOU EVER	
		Palpitation or pounding heart			Recurrent back pain		Been treated for a female disorder
		Heart trouble			"Trick" or locked knee		Had a change in menstrual pattern
		High or low blood pressure			Foot trouble		ARE YOU PREGNANT
✓		Cramps in your legs			Neuritis		SUSPECT YOU ARE PREGNANT
	/	Frequent indigestion			Paralysis (include infantile)		
		Stomach, liver, or intestinal trouble			Gall bladder trouble or gallstones		
		Jaundice or hepatitis					

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury noted? (If yes, specify when, where, and give details.)
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
		C. Inability to assume certain positions.			
		D. Other medical reasons (If yes, give reasons.)			20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
/		14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).			21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
		15. Have you ever been denied life insurance? reason and give details.)			
		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE | SIGNATURE

INTAKE SCREENING

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.T. ___
OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS. PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW

IF DRUGS HAVE BEEN USED NOTE TYPE, HOW LONG, HOW MUCH HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED, HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ___

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS TEMPORARY ___ RESTRICTED ___
GENERAL POPULATION YES ___ NO ___
TYPE AND EXTENT OF RESTRICTION ___

23. Physician's summary and elaboration of all pertinent data. Physician shall comment on all positive answers in Item 6 through 22. Physician may develop by interview any additional medical history he deems important. Also record any significant findings here

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
	SEP 23 1998		

Brian Cromwell
Registered Nurse
Federal Transfer

Known Drug Allergies: No Known Allergies: Complaint of ___
Present Medical Status: No Complaints
Signs and Symptom(s): None. cough, hemoptysis, night sweats, wt.los

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
KEVIN L. SIGGERS	

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening		Federal Transfer Center, Oklahoma City, OK

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

MAR 18 1996

7. HAVE YOU EVER (Please check each item)			8. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis	✓		Wear glasses or contact lenses
	✓	Coughed up blood	✓		Have vision in both eyes
	✓	Bled excessively after injury or tooth extraction		✓	Wear a hearing aid
	✓	Attempted suicide		✓	Stutter or stammer habitually
	✓	Been a sleepwalker		✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to				Epilepsy or fits
	✓		Rheumatic fever		✓		drug or medicine				Car,train,sea or air sickness
			Swollen or painful	✓			Broken bones				Frequent trouble sleeping
			joints		✓		Tumor,growth,cyst,cancer				Depression or excessive worry
			Frequent or severe		✓		Rupture/hernia		✓		Loss if memory or amnesia
	✓		headache		✓		Piles or rectal disease				Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or				Periods of unconsciousness
			spells		✓		painful urination				Have you ever had
✓			Eye trouble		✓		Bed wetting since age 12		✓		homosexual contact?
			Ear,nose,throat trouble		✓		Kidney stone or		✓		Been exposed to AIDS
	✓		Hearing loss		✓		blood in urine	✓			Alcohol Use (Excessive)
	✓		Chronic, frequent colds		✓		Sugar, albumin in urine	✓			Drug Use/Addiction
	✓		Sever tooth, gum trouble		✓		VD-Syphilis, gonorrhea,	✓			Marijuana
	✓		Sinusitis		✓		etc.		✓		Cocaine
	✓		Hay Fever		✓		Recent gain or loss of				Heroin
	✓		Head injury				weight		✓		L.S.D.
	✓		Skin diseases				Arthritis, Rheumatism,		✓		Amphetamines
	✓		Thyroid trouble				or Bursitis				Others: (Specify)
	✓		Tuberculosis	✓			Bone, joint or				
	✓		Asthma		✓		other deformity		✓		Alcohol or drug
	✓		Shortness of breath		✓		Lameness				Withdrawal Problems

(This form may be replicated via WP) This form replaces BP-360(60) dated January 1986.

✓			Pain, pressure in chest				Loss of finger or toe				
✓			Chronic cough				Painful or "Trick"				
✓			Palpitation or pounding				shoulder or elbow				10. FEMALES ONLY HAVE YOU EVER
✓			heart				Recurrent back pain				Been treated for a
✓			Heart trouble	✓			"Trick" or locked knee				female disorder
✓			High or low blood	✓			Foot trouble				Had a change in
✓			pressure	✓			Neuritis				menstrual pattern
✓			Cramps in your legs				Paralysis (include				ARE YOU PREGNANT
✓			Frequent indigestion				infantile)				SUSPECT YOU ARE PREGNANT
✓			Stomach, liver, or				Gall bladder trouble or				
✓			intestinal trouble				gallstones				
✓			Jaundice or hepatitis	✓							

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury noted? (If yes, specify when, where, and give details.)
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons (If yes, give reasons.)		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	✓	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	✓	15. Have you ever been denied life insurance? reason and give details.)			
✓		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
	✓	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___
OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ___

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___
GENERAL POPULATION ___ YES ___ NO
TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important and record any significant findings here.)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Jason Genzel, LT/C, Registered Nurse F.T.C., Oklahoma City, OK	MAR 18 1998		

Food or Drug Allergies: NKA: Allergies: ___
Current Medical Status: No Complaints: Complaint of ___
TB Signs and Symptom(s): NONE; cough, hemoptysis, night sweats, wt.los

BP-S354.060 **INTAKE SCREEN (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCI McKean	10/21/98	1500

Inmate's Name	Register Number
Diggers, Kevin	51627-060

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☐ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: Pending Medical clearance

Medical Staff Signature	Date	Time
W. Hamaker	10/21/98	12 25

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCRE** **(MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE

(Medical staff shall complete this sc
Institution)

SIGGERS
KEVIN L 51627-060
B/M/O/08-22-1970
HT/601WT/230HR/BKEY/BN
CUSTODY/IN

Institution	Date of

Inmate's Name

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date SEP 23 1998	Time
Medical Staff Title Brian Cronenweth, LT. Registered Nurse Federal Transfer Center, OKC, OK		

Record Copy - Inmate Central File; Copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg	10/13/98	1835

Inmate's Name	Register Number
Siggers	51627-060

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☒ no (Specify limitation or need) HTO

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions) HTO

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
[signature]	10/13/98	2120

Medical Staff Title Hope E. Zeiber, RN

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. SIGGERS
KEVIN L
(Medi B/M/O/08-22-1970 51627-060
Insti HT/601 WT/230 HR/BK EY/BN
CUSTODY/IN
Insti

Inmat

FEDERAL BUREAU OF PRISONS

form on all arrivals to the

Time of Arrival

er Number
FMC Rochester, MN

M E D I C A L A R R A N C E

1. BP-149(60) reviewed? ☐ yes; ☑ no (Explain)

2. General Population Housing Approved? ☐ yes; ☑ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☑ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☐ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature Gary J. Kunz FNP-C | Date 3/26/98 | Time 2100

Medical Staff Title

Gary J. Kunz, FNP-C
FMC Rochester, MN

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **F PRISONS**

(Medical staff shall compl to the Institution)

Institution

SIGGERS
KEVIN L 51627-060
B/M/O/08-22-1970
HT/601WT/230HR/BKEY/BN
CUSTODY/IN

Inmate's Name

M E D I N A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date MAR 18 1998	Time
Medical Staff Title Jason Genzer, LTJG Registered Nurse F.T.C., Oklahoma City, OK		

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

OPT A 11

BILL TO: DIANE CALDWELL
FCI MC[illegible]AN HEALTH SVC
RT 59B[illegible] SHANTY ROAD
LEWIS RUN
PA, 16738

PATIENT NAME 51627-060 LI-E 110666 | CUST. NUMBER FC CALDWELL | INVOICE NUMBER 205360

Tray No. 3519 | Date Processed 11/09/2005 | 11/23/2005

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	-1.75	-0.50	150		6.00
L. EYE	-2.00				6.00

	Add	Width	Height
R. EYE			0.0
L. EYE			0.0

	P.D.	N.P.D.
R. EYE	70.0	
L. EYE	70.0	

FRAME DATA

Size 48.0 | Depth 41.0 | E.D. 48.0 | D.B.L. 24.0

Model: 74-74VF | 032027167[illegible] | TMPL. Length: 48X24 | SMOKE

EDGED UNCUT ☐☐ | LENS ONLY ☐ | ENCLOSED ☐ | TO COME ☐ | SUPPLIED ☒

LENS DATA

	Type	Material
R:	SV CR-39 CLEAR SOLA 72	
L:	SV CR-39 CLEAR SOLA 72	

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

CHARGES

DESCRIPTION	PRICE
RIGHT LENS	11.
LEFT LENS	11.
74-74VF	12.
SAFETY	
Sub Total	34.
Freight	
Total Due	34.

COMMENTS:

J-10245543 LI-E T-3519

OPT A 20

FROM: 110666
53604

POSTMASTER
IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER.

SHIP TO: FCI MCKEAN HEALTH SVC
RT 59 BIG SHANTY RD
LEWIS RUN, PA. 16738

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
OPTOMETRIST	Dennis Olson, MD, CD	

REASON FOR REQUEST (Complaints and findings)

EYE EXAM:

SUBJECTIVE:

-1.75 -.50 X170
-2.00 -.50 X 20
48X2446

PROVISIONAL DIAGNOSIS

70

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION			
D. OLSON, M.D.		☐ BEDSIDE	☐ ON CALL	☐ ROUTINE ☐ 72 HOURS	☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD 20/200 OS 20/200 OD
Near OD .37m OS .37m TONOMETRY: Uncorrected OS

External normal 70
Internal media clear, fundus normal
Refraction OD -1.75 -.50 X150
-2.00

48X2446

Diagnosis Myopia

Analysis requires eyeglasses

Plan order eyeglasses

(Continue on reverse side)

SIGNATURE AND TITLE		DATE
Christine Howard OD		11/3/04

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
	FCI McKean	57627-060	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Foggers, Kevin

Reviewed by D. Olson, MD
Date: 11/3/04

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Optometrist - Dr. Howard	Dennis Olson, MD, CHP	

REASON FOR REQUEST (Complaints and findings)

Eye Exam

Subjective:

-1.50 -.50 x 160
-1.75 -.50 x 25.

PROVISIONAL DIAGNOSIS

dep 32

70
52 x 24 x 6

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
D. Olson, MD Clinical Director		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO — PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity — Distance OD 20/20 OS 20/20 — TONOMETRY: OD / OS

Near OD .37 m OS .37 m

External normal 70

Internal Media clear, fundus normal

Refraction OD -1.75 -.50 x 170 20/20
OS -2.00 -.50 x 20 20/20

48 x 24 x 6

Diagnosis CMA

Analysis require eyeglass optics

Plan order BOP Rx glasses

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
Christian Howard OD			10/23/02
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
	FCI/FPC McKean	516 27-060	

PATIENT'S IDENTIFICATION (For typed or written entries, name—last, first, middle initial; and name of medical facility)

10/23/02

D OLSON, M.D.

Siggers, Kevin

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV.)
Prescribed by GSA/ICMP — CFR) 201-9.202-1